

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>003283</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/30/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY CHARM VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7212 US HWY 31 S</b> <b>INDIANAPOLIS, IN 46227</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00177115 and IN00179064.</p> <p>Complaint IN00177115 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00179064 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: July 29 &amp; 30, 2015</p> <p>Facility number: 003283 Provider number: 003283 AIM number: n/a</p> <p>Census bed type: Residential: 57 Total: 57</p> <p>Census payor type: Medicaid: 40 Medicare: 17 Total: 57</p> <p>Sample: 4</p> <p>Country Charm Village was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00177115 and IN00179064.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE